

# CIN Partners Share:

## Behavioral and Physical Health Care: Better Together

The California Improvement Network (CIN) partners — public and private health care organizations actively engaged in improving care delivery — meet quarterly to share experiences and to learn from one another. Following are highlights from the partners' July 2015 meeting, which focused on the integration of behavioral health care with physical health care.

**Main Takeaway: The large-scale integration of behavioral with physical health care in California is still in its infancy. To make progress, providers, health plans, and regulators need to leverage policy and funding opportunities and create a new shared focus on measuring care outcomes.**

### Background

Behavioral and physical health care are often delivered and managed separately, creating obstacles to optimal population health, barriers for patients seeking care, and challenges for providers caring for patients who need both types of services. These two sides of care have traditionally been managed through separate regulatory systems, financing models, data systems for documentation, and sites of care. (See Figure 1.) CIN partner organizations and presenters discussed new care models and collaborations, as well as opportunities in policy and funding, meant to improve care integration.

#### Defining terms

The integration of behavioral health and primary care is the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care use.<sup>1</sup>

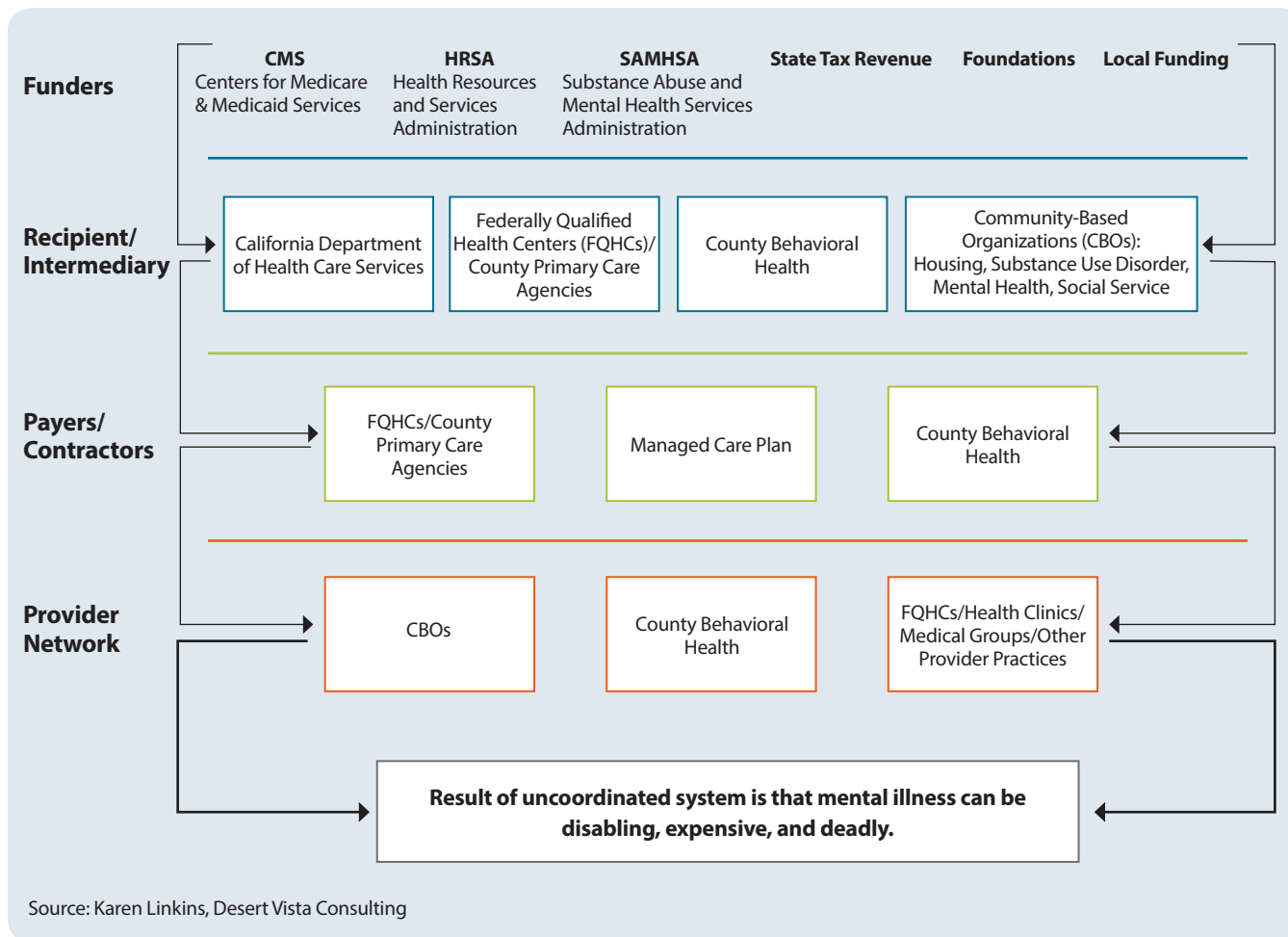
Integration occurs on a continuum from minimal coordination to colocated care to full integration. Minimal coordination is simple referrals and periodic communication among providers. Colocated care occurs when primary care and behavioral health providers share a facility; the level of coordination will vary even with colocation.<sup>2</sup>

Partners discussed recent changes in the health policy and funding environments that have focused attention on the integration of behavioral health with physical health care. Two of these changes are Affordable Care Act (ACA)-related expansions to Medi-Cal: one broadens eligibility, and the other increases benefits.

- **Medi-Cal *eligibility expansion*** affects behavioral health services by bringing more single adults into the Medi-Cal program and into Medi-Cal managed care. The behavioral health needs of this population are great, and demand is expected to strain an already thin behavioral health delivery system.
- **Medi-Cal *benefit expansion*** requires Medi-Cal managed care plans to cover mental health services, including Screening, Brief Intervention, and Referral to Treatment (SBIRT) services, other than the specialty mental health services administered by counties. This benefit expansion is generally meant to serve individuals with mild-to-moderate mental health conditions. The expansion of benefits to this population highlighted the need to better coordinate resources between health plans, counties, primary care providers, specialists, and behavioral health service providers.

Figure 1

### Financing Behavioral Health Care in California: Uncoordinated Care from Unaligned Funding



Other changes on the horizon have the potential to facilitate integration and improve the delivery of mental health and substance use disorder (SUD) services.

- California is the first state to receive a federal funding waiver to transform the way SUD treatment services are delivered in Medi-Cal. *The Drug Medi-Cal Organized Delivery System (DMC-ODS)* waiver, approved by the Centers for Medicare & Medicaid Services (CMS) in August 2015, requires participating counties to provide a full continuum of evidence-based SUD services.
- The ACA’s *Section 2703 Health Homes* opportunity for states provides funding to develop enhanced services for Medicaid beneficiaries with complex care needs — typically, those with medical conditions who also have behavioral health diagnoses.
- *Certified Community Behavioral Health Clinics (CCBHC)*, a new designation created by Congress in 2014, will provide full-scope services for those with serious and persistent mental illness, as well as for those with substance use disorders. CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) have been collaborating on the design of the CCBHC demonstration program, which will award planning grants to states in 2015-2016.

***“In behavioral health care, a culture change needs to happen where we shift to rigorous measurement of clinical outcomes and patient-reported health status, and the use of these data to improve care.”***

## From the Field

### **AltaMed Health Services Corporation** [www.altamed.org](http://www.altamed.org)

Founded in 1969, AltaMed is the largest independent Federally Qualified Health Center (FQHC) in the United States, operating 43 sites in Los Angeles and Orange Counties and delivering more than 930,000 annual patient visits. AltaMed also manages an independent practice association (IPA) with 153 contracted primary care physicians and 471 specialists.

AltaMed has expanded behavioral health services for mild-to-moderate mental health and substance use disorder needs and integrated these services with physical health care through colocation with primary care teams in seven clinic sites.

#### **Building a Department and Internal Processes**

Over the past three years, AltaMed has developed dedicated behavioral health services within primary care through a new staff department and a growing range of services.

AltaMed uses multiple behavioral health interventions: cognitive behavioral therapy; motivational interviewing; short-term problem-solving therapy; short-term trauma-focused therapy; SBIRT; and child and family therapy. AltaMed's care teams also provide targeted counseling on topics such as parenting skills and HIV care. Behavioral health staff join the primary care staff in team huddles.

There is no in-house psychiatry at AltaMed. AltaMed refers patients with serious mental illness to the closest specialty mental health center. An AltaMed nurse manager meets weekly with that clinic's providers to coordinate care, with consent from patients.

#### **SBIRT in Medi-Cal**

Effective January 1, 2014, Medi-Cal providers began implementing the Screening, Brief Intervention, and Referral to Treatment (SBIRT) assessment and intervention benefit to Medi-Cal beneficiaries. The benefit is to be offered annually to all Medi-Cal beneficiaries 18 years and older in primary care settings. SBIRT is a health promotion approach for delivering early intervention and treatment services to people with, or at risk of developing, alcohol use disorders.

As its name implies, SBIRT has three components: screening, brief intervention using motivational interviewing, and referral to specialty care treatment for patients with illicit drug use problems. In California, Medi-Cal has rolled out SBIRT for alcohol use disorders.

A key aspect of SBIRT is the integration and coordination of screening, early intervention, and treatment components into a system of care. This system links community health care and social services programs with specialty treatment programs.

AltaMed's SBIRT process involves the entire behavioral health team. A medical assistant (MA) administers a one-question screening tool, and then asks three

additional questions of those patients who respond positively to the first. If the patient responds with more positive answers, the MA calls in the provider, who does a brief intervention. Then the provider introduces the patient to a promotora (a lay community member who receives specialized training to provide basic health education without being a professional health care worker), who follows up with the patient by phone to encourage and track progress in self-management. An identified SBIRT team at each clinic consults with all primary care teams at the site.

CIN partners are supporting SBIRT implementation in many ways:

- AltaMed is partnering with researchers to test SBIRT effectiveness with substances other than alcohol.
- Partnership HealthPlan of California initiated a quality bonus to allow providers to bill for SBIRT.
- Inland Empire Health Plan offers a four-hour online training program for its providers, through [www.sbirthraining.com](http://www.sbirthraining.com), although most providers need more training and support.

Start-up costs for these new services and staff were an up-front investment. “You will have losses” initially, said Program Supervisor Zares Soto, who talked about the time it took to engage patients in the new services and the high no-show rates for appointments with the behavioral health team during that initial period. AltaMed eventually created a new staff position responsible for outreach, scheduling, and appointment reminders. The program became self-sustaining in its third year.

AltaMed is developing a measurement dashboard for its behavioral health department with the same five categories it uses to evaluate overall organization strategy.

**1. Quality:**

- Depression and anxiety symptom scores using the Patient Health Questionnaire-9 and Generalized Anxiety Disorder 7-item scale screening tools, with the goal of a seven-point drop in scores, reflecting reduction in depression and anxiety symptoms
- Results of a qualitative survey (under development) that measures quality of psychotherapy services

**2. Service:** Cycle time, appointment delay, patient experience surveys

**3. People:** Employee turnover rate (with the goal of 10% or lower)

**4. Finance:** Revenues, expenditures, billable visits, no-show rate

**5. Community:** Measures under development

*“We need to design care for the cyclical nature of most mental illness. The strict boundary between ‘mild-to-moderate’ on one side and ‘serious and persistent’ on the other is unnatural.”*

To recruit staff for this new service department, AltaMed partners with social work graduate programs, and participates in an LA County multi-organization work group on behavioral health workforce needs.

AltaMed’s behavioral health program bills separately for patients with coverage for these services, which are not part of existing capitation arrangements with payers. AltaMed developed a workflow tool to help with the referral process and help patients access services based on the payer. Behavioral health managers coach the billing department in behavioral health coding, to continue to increase accepted claims for services provided.

To improve communication and care coordination among the care team, AltaMed is currently working to maximize use of its electronic health records (EHR) system. Staff members are using the system to share information while restricting the flow of clinical information between physical and behavioral health services. AltaMed trained clinicians to document their care using two templates within its NextGen EHR: one for psychotherapy notes (which are restricted under HIPAA — the federal Health Insurance Portability and Accountability Act of 1996 — and other regulations), and one for nonrestricted information (including diagnosis, medication, and treatment plans), which can be shared.

**Building a Behavioral Health Department at AltaMed: Timeline**

Year 1	Year 2	Year 3	Future Steps
<ul style="list-style-type: none"> <li>■ Launch behavioral health department for mild-to-moderate needs, with 1 clinician</li> <li>■ Initiate SMI coordination with outside providers</li> <li>■ Add behavioral health interventions in primary care</li> </ul>	<ul style="list-style-type: none"> <li>■ Hire behavioral health team members</li> <li>■ Add weekly consults with SMI providers to coordinate care</li> <li>■ Tailor EHR for compliant and useful behavioral health documentation</li> </ul>	<ul style="list-style-type: none"> <li>■ Program becomes financially self-sustaining</li> <li>■ Team grows to 8 clinicians at 7 sites</li> <li>■ Begin work with partner organizations to build health neighborhoods</li> </ul>	<ul style="list-style-type: none"> <li>■ Add more quality reporting, information management in EHR</li> <li>■ Enhance SMI care coordination, record sharing</li> <li>■ Move into future clinic sites tailored for fully integrated care</li> </ul>

## Evaluation and Next Steps

The organization uses an 11-question survey that has been modified for behavioral health to measure patient experience. AltaMed reports promising results in a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of 60 patients who completed a series of visits with behavioral health providers. To further evaluate this program, AltaMed will analyze behavioral health care patients' blood sugar levels (for patients with diabetes), blood pressure, emergency department use, and hospital use.

To formally document staff experiences as the behavioral health team's work evolves, AltaMed will survey primary care providers and the behavioral health team. In informal conversations, AltaMed's primary care providers reported that they appreciate the ability to do warm handoffs to behavioral health colleagues and that they value the additional expertise and services provided by the behavioral health team.

AltaMed's future plans include further development of internal capacity and expertise, and building relationships with external providers. Please see the diagram on page 4 for a graphic representation of its progress.

## L.A. Care Health Plan [www.lacare.org](http://www.lacare.org)

Established in 1997, L.A. Care Health Plan is an independent local public agency created by California to provide health coverage to low-income Los Angeles County residents. Serving more than 1.8 million members in five health plans, it is the nation's largest publicly operated health plan.

### The Changing Role of Health Plans in Behavioral Health

L.A. Care is participating in California's Coordinated Care Initiative, called Cal MediConnect, a demonstration program launched in seven California counties that seeks to better coordinate care for individuals who are beneficiaries of both the Medi-Cal and Medicare programs. With the addition of this population, as well as the newly covered single adult population, Medi-Cal health plans are responsible for care management for a larger population of members with more complex care needs and patterns of greater hospital utilization.

These changes mean that Medi-Cal health plans have a new responsibility for behavioral health services. The behavioral health department at L.A. Care has grown from one clinical leader to a team of 25, as more services — such as case management and managed autism services — have been added to health plan responsibilities.

The behavioral health team includes project managers, case managers, and a data analyst. The team's strategic initiatives include developing services for transgender individuals, patients with autism, and those who are homeless. To achieve L.A. Care's goals and to align with the rest of the health plan, the behavioral health team "infiltrates" other departments within the health plan, including the quality improvement department, and organizes improvement-focused collaborative projects. For example, as part of L.A. Care's autism benefit initiative, representatives from the four health plans providing the new benefit meet regularly with the seven regional centers responsible for autism care.

### Challenges

L.A. Care's members confront several challenges to the realization of a fully integrated behavioral health system, including coordination and communication among the large numbers of partner organizations providing behavioral health services, and barriers to sharing clinical information at the patient level for care coordination. Privacy concerns and the limits of information systems to directly communicate across the range of systems used by different agencies pose barriers to care coordination.

The business relationships are another work in progress: Many behavioral health service providers have never had managed care relationships before. For L.A. Care, this has required ongoing meetings and training within its Utilization Management, Claims, and other plan departments.

## Looking Ahead

To continue to improve its network's capacity and capabilities, L.A. Care is developing tools such as a universal consent form for care coordination, and hosting frequent training sessions and conferences for health plan members and care providers on topics including SBIRT, LGBT health, and autism care. Goals for future work include:

- Continuing to improve care coordination with care providers, including its own staff
- Continued training of its provider network on managed care, and of the L.A. Care staff on behavioral health
- Developing a peer support and peer education program for health plan members with behavioral health needs

## Asked and Answered !

### *How might telehealth be used to address behavioral health needs?*

California HealthCare Foundation's February 2015 Innovations Showcase focused on behavioral health and included a sampling of vendors that provide web-based or remote services. For details, visit [www.chcf.org/publications/2015/02/innovation-showcase](http://www.chcf.org/publications/2015/02/innovation-showcase).

The San Francisco Health Network uses its telemedicine platform and e-referral system for provider-to-provider consultation on behavioral health needs and psychiatric medication management. For example, in a visit with a child and parent, a primary care provider can add a psychiatrist to the discussion. Partnership HealthPlan also uses a telemedicine platform for provider-to-provider consultation. This use of provider time is unreimbursed in most cases. Partners have also piloted online cognitive behavioral therapy products but reported difficulties in engaging consumers to use the tools.

### *How is your organization measuring the quality of behavioral health services for your patient/member populations?*

While partners reported that it was difficult to identify the "right" measures for behavioral health, many are testing the following:

- Use of behavioral health services
  - No-show rates
  - Productivity of behavioral health staff (e.g., percentage of visit supply used)
  - Call abandonment rates, as a place to start gathering data on people who tried to get an appointment but did not
  - Percentage of patients who screen positive for depression and for smoking who receive a "touch" (i.e., outreach or services) with behavioral health staff embedded in primary care clinics
- Physical health measures in the Healthcare Effectiveness Data and Information Set (HEDIS), such as HbA1c testing and control for diabetes, for patients receiving behavioral health services
- For patients with depressive symptoms, improvement in PHQ-9 results

AltaMed has a monthly dashboard with six measures, including some of the measures listed, as well as staff turnover rate to measure staff experience. As progress in measuring improvement in behavioral health care is behind measurement in physical health care, many partners have not yet developed performance measures but are planning to do so.

### *Are you focusing on specific patient populations as you work to improve integrated care?*

- **Adults with attention deficit/hyperactivity disorder (ADHD):** With many newly covered employed patients coming to their clinics for the first time, some safety-net partners are seeing more adult patients with an ADHD diagnosis. Many providers are not willing to prescribe stimulant medications to adults. At the same time, ADHD is underdiagnosed and therefore undertreated in adults.



*Asked and Answered (cont.)*

- **Children:** Partners reported that behavioral health services are particularly fragmented for the pediatric population.
- **Transgender individuals:** L.A. Care matches transgender members to providers with expertise in transgender health.
- **Substance-misusing and -dependent patients who are candidates for medication-assisted addiction treatment:** L.A. Care is looking at national models of medication-assisted addiction treatment being implemented through collaborative initiatives. Meanwhile, L.A. Care sends reminders about metabolic testing to patients on these treatments.

**How has your organization approached trauma-informed care?**

Trauma-informed care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Partners are at the beginning stages of planning to implement this level of care integration, and are aware of the substantial investment, ongoing training, and organizational culture change required.

**Resources**

- Review of 79 randomized controlled trials finding collaborative care for people with depression and anxiety to be better than routine care: [www.cochrane.org/CD006525/DEPRESSN\\_collaborative-care-for-people-with-depression-and-anxiety](http://www.cochrane.org/CD006525/DEPRESSN_collaborative-care-for-people-with-depression-and-anxiety)
- SAMHSA resources and guidelines for medication-assisted treatment: [dpt.samhsa.gov](http://dpt.samhsa.gov)
- Effective medication-assisted treatment for substance abuse/dependence: [archinte.jamanetwork.com/article.aspx?articleid=226781&resultClick=3](http://archinte.jamanetwork.com/article.aspx?articleid=226781&resultClick=3)
- CCBHC demonstration program:
  - SAMSHA information and application: [www.samhsa.gov/about-us/who-we-are/laws-regulations/section-223](http://www.samhsa.gov/about-us/who-we-are/laws-regulations/section-223)
  - California Department of Health Care Services' Mental Health Services Division's application to SAMHSA for a planning grant: [www.dhcs.ca.gov/services/Documents/CCBHC\\_Grant\\_Application\\_Rev.08.07.15pdf.pdf](http://www.dhcs.ca.gov/services/Documents/CCBHC_Grant_Application_Rev.08.07.15pdf.pdf)
  - SAMSHA resources on Trauma-Informed Care: [www.samhsa.gov/nctic/trauma-interventions](http://www.samhsa.gov/nctic/trauma-interventions)

**Endnotes**

1. Peek CJ and the National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. AHRQ Publication No. 13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2013. Available at: <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>.
2. Heath B, Wise Romero P, and Reynolds K. *A Standard Framework for Levels of Integrated Healthcare*. Washington, DC: SAMHSA-HRSCenter for Integrated Health Solutions; April 2013. Available at: [www.integration.samhsa.gov/integrated-care-models/A\\_Standard\\_Framework\\_for\\_Levels\\_of\\_Integrated\\_Healthcare.pdf](http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf).



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